Written Testimony to the Illinois Health Care Reform Implementation Council
From the Sargent Shriver National Center on Poverty Law
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The Sargent Shriver National Center on Poverty Law provides national and state leadership in identifying, developing, and supporting creative and collaborative approaches to achieve social and economic justice for low-income people and communities in a variety of policy areas, including working to ensure quality, affordable health care for all. Thank you for the opportunity to provide recommendations on opportunities and responsibilities in the Affordable Care Act (ACA) implicating the Medicaid program. The Shriver Center's recommendations follow, grouped into four broad areas.

- Implications of ACA's Medicaid Expansion for Illinois' Medicaid Program
- Ensuring Continuity of Health Care in Benefits Coverage and in Provider Networks in Medicaid and on the Exchange
- Care Management and the Integration of Medical Services into Medicaid
- Other Changes to Improve the Medicaid Program

IMPLICATIONS OF ACA'S MEDICAID EXPANSION FOR ILLINOIS' MEDICAID PROGRAM:

The historic number of uninsured people during these turbulent economic times underscores the need for the successful implementation of reform to stabilize health coverage for Illinois' families. The ACA's expansion of Medicaid coverage to individuals with gross adjusted household incomes up to 133 percent of the federal poverty line takes a colossal step forward in covering an estimated 700,000 Illinoisans or an estimated 27 percent of Illinois' uninsured (Community Catalyst). Federal funds will pay for most of the resulting costs of the expansion, but there will be modest increases in state Medicaid spending, representing increases of 1.4 to 2.9 percent relative to what states would spend on adults in the absence of federal reform (Robert Wood Johnson Foundation and the Urban Institute). The UnitedHealth Center for Health Reform estimated that the cost due to the Medicaid expansion is $12.56 billion: $12.03 billion paid by the federal government and $525 million paid by Illinois.[1] This is a significant reduction in the number of uninsured at a relatively low cost to Illinois. And the federal match means that Illinois will extend health coverage to about 5 percent of its population at a cost of just $40 per

[1] Note: UnitedHealth Center for Health Reform estimated that Illinois' will see an expansion enrollment of 23% (an additional 542,150 enrollees).

person annually.[2]

Data from the Urban Institute reveal that the "newly eligible" population will tend to be heavily male, between the ages of 19 and 34 years old. The table below shows the number of nonelderly, uninsured persons in Illinois by poverty level.

Distribution of Nonelderly Uninsured in Illinois by by Federal Poverty Level (FPL): 2007-2008	
Under 100%	648,700
100-133%	163,400
134-300%	557,000
301-400%	119,500
Over 400%	159,300
Total	1,647,900

Source: The Kaiser Family Foundation, *statehealthfacts.org.*

This population will likely be unfamiliar with Illinois' public health insurance programs either because they have never been eligible for such a program, or if they were, they were enrolled years or even decades earlier. (However, some will have been enrolled in Medicaid or All Kids as children or parents and lost coverage as their age/status changed.) A large majority will have had no usual source of health care and a greater number not having seen a doctor in recent years except on an ad hoc, emergency basis.

Illinois should learn from other states that already provide Medicaid eligibility to childless adults, and this experience may provide valuable lessons, such as New York.[3] The New York experience demonstrates that this population is among the hardest to reach and enroll. Despite the fact that New York has extended Medicaid eligibility to childless adults for more than four decades and enrolled close to 1 million persons, 520,000 uninsured childless adults are eligible for public coverage but not enrolled, representing one-third of the 1.6 million uninsured childless adults in the state. Lessons from New York about this population include:

- Childless adults are significantly more likely than parents to be very young (age 19-25) or older adults (age 55-64).
- They are also more likely to be male, poor, non-working, and in fair or poor health.
- Noncitizen childless adults have the highest uninsured rate among all childless adults.
- Childless adults have the lowest public program participation rates among all eligibility groups.
- This population is "more likely to be transient, be in crisis, have other priorities, or simply be disconnected from stabilizing forces such as family, schools, or other institutions."

[2] http://www.progressillinois.com/quick-hits/content/2010/03/23/cost-medicaid-expansion.
[3] See: Enrolling Childless Adults in Medicaid: Lessons from the New York Experience and Opportunities in Health Reform, The Medicaid Institute at United Hospital Fund, October 2010.

- Many childless adults, especially men, assume they are not eligible for public health insurance given the widespread emphasis on enrolling children and families. Others assume that having a job of any kind will disqualify them from public coverage. Further, many have fluctuating income because they work intermittently or seasonally, which makes them intermittently eligible for public coverage.
- Childless adults who applied for coverage at a Medicaid office reported negative experiences, while those who applied through a community-based enroller described the experience quite favorably.

Recommendations:

Conduct a needs assessment analysis on Illinois' newly eligible population. Illinois should conduct a needs assessment analysis in order to better understand this newly eligible population. The assessment would focus on their healthcare needs, access issues, and their connection to existing public services and programs. It should include data collection from FQHCs, clinics, emergency rooms, as well as mental health and substance abuse treatment providers and direct service providers who work with the homeless. Moreover, Illinois should conduct focus groups with Medicaid enrollees and consumers in order to assess areas for improvement in the current Medicaid system, including enrollment and access to benefits. This data will greatly prepare Illinois for the significant opportunity that lies ahead in providing meaningful coverage to this new population.

Additionally, this analysis could also include identifying how many Illinoisans currently obtain coverage through the individual or small group markets, employer based coverage, or through public programs, and at what average cost. This assessment should be conducted annually. Tracking these proportions will allow Illinois to see which sources of coverage are shrinking and which are growing. This way, Illinois will know where special attention would be warranted to ensure that the Exchange meets the needs of certain populations.

Outreach to the newly eligible population about upcoming access to coverage. The newly eligible population is here now, and many of them are currently getting medical care—although that care may be disorganized, chaotic, and, alas, expensive. Because the federal government will bear nearly all of the costs of covering this population through Medicaid, there is a clear incentive for Illinois to enroll them rather than pay for their care through uncompensated care subsidies should they seek care while uninsured (particularly since uncompensated care subsidies will decline under the ACA). Outreach to them about the impending Medicaid coverage as soon as possible and in their usual health care settings will increase the likelihood of their enrollment in the program once it becomes available in the future. Community based organizations will and should be heavily relied upon to enroll Medicaid eligible individuals. The newly eligible population will most likely not have been connected to many public benefit programs in the past (decreasing the likelihood of the existence of data to pre-populate enrollment forms). There will be an increased need for community-based staff (navigators under ACA) to enroll individuals. It is important for Illinois to have an outreach strategy in place and ready to implement as soon as

possible. The report on New York's childless adult group included the following suggestions to reduce obstacles faced by this population in obtaining health insurance:

- Increase publicity about the importance and availability of public coverage for childless adults;
- Consider re-branding the Medicaid program so it is clear that childless adults are eligible;
- Make better use of available data to prove eligibility to minimize burden on applicants of providing documentation;
- Implement 12-month continuous eligibility for adults and advocate for the elimination of reporting requirements for changes in eligibility during that period; and
- Consider mechanisms for using an annual average of income for eligibility.

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Moreover, Section 2201 of ACA specifically requires the state to outreach to children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance- related disorders, and individuals with HIV/AIDS. This provision suggests a legal obligation to enroll eligible individuals and Illinois needs to effectively implement this requirement to maximize the benefit of the new coverage expansions.

The needs assessment discussed above, if undertaken, will also produce greater insight into the newly eligible population and the ways to reach them.

Ensure that the Medicaid population receives a full comprehensive benefits package. Those newly eligible for Medicaid under the expansion are to receive a "benchmark" benefit package that states can currently provide to some populations as an alternative to mandatory benefits under traditional Medicaid. Beginning January 2014, benchmark coverage must include at least the "essential health benefits" available through the Exchange. Both the currently eligible and the newly eligible populations in Medicaid should receive the same comprehensive benefits package. Given the extremely generous federal support for the newly eligible population, including a 100 percent federal match from 2014 through 2016 and a 90 percent match in 2020 and indefinitely on, Illinois has a significant financial incentive to provide comprehensive coverage to the newly eligible group. Ensuring that all adult enrollees have the same benefit package will simplify administration and reduce any confusion among enrollees.

Also, Illinois' current Medicaid benefits package still lacks important services such as adult dental care. There is nothing in the ACA that would prevent Illinois from adding this or other critical medical services to the current package and applying them to the new expansion group as well. Moreover, the decisions regarding the benefits package should be made very carefully with input from all relevant stakeholders, including advocates for Medicaid beneficiaries.

Carefully study the benefits to the state to implement early expansion of Medicaid. While Illinois must implement the Medicaid expansion as of January 1, 2014, the state does have the option to provide coverage to this population earlier. While mindful of Illinois' current budget difficulty and the fact that the enhanced FMAP funds are not available until January 1, 2014, we recommend that HFS consider the fact that early implementation would provide Illinois the

opportunity at least to *phase in* the Medicaid expansion. The time period immediately before and after January 1, 2014 is very likely to be stressful to say the least as the state works to rollout the new exchange, subsidies, premium tax credits, and other insurance market reforms. Expanding Medicaid early would provide some administrative relief so that HFS and its sister state agencies are less overwhelmed on January 1, 2014. At a minimum, Illinois should consider opening the application and eligibility determination process for the expansion population well ahead of January 1, 2014—think of students applying for college admission: they apply and are admitted many months ahead of the day the show up for classes. Medicaid could work in a similar fashion. Moreover, there are local (county and municipality) health care funds currently being spent on providing or reimbursing for medical services to current persons who will later qualify in the newly eligible population. Expanding Medicaid now to the poorest of this population, will capture at least a 50 percent federal match, allowing local dollars to be put to good use elsewhere.

Explore the option of requesting a waiver to cover those who otherwise would fall out of the system but be eligible in 2014. We also recommend exploring the option of requesting a waiver from CMS to cover early the current Medicaid enrollees who otherwise would be coming off the Medicaid program prior to January 1, 2014—for instance young people who would otherwise age off the program and parents who would otherwise lose eligibility when their children age off. Keeping these persons covered and in continuity of care will save money over time and they will be using relatively low cost primary and preventive care. This will decrease the likelihood of acute medical episodes that might otherwise happen due to a lack of primary and preventive care.

Explore requesting waivers or expanding early to cover other vulnerable currently ineligible groups. As Illinois plans for 2014 it should also explore the entire range of options for covering more of Illinois lowest income residents, particularly vulnerable populations whose unaddressed or intermittently address health care needs make their lives less healthy and end up costing more when eventually treated. People who are homeless, people who are mentally ill, people who cycle in and out of jail are just a few of such groups.

ENSURING CONTINUITY OF HEALTH CARE IN BENEFIT COVERAGE AND IN PROVIDER NETWORKS IN MEDICAID AND THE EXCHANGE:

Recommendations:

Apply for new federal funding to streamline and upgrade Illinois' Medicaid eligibility system. In order to fund the overwhelmingly majority of the cost of a streamlined, no wrong door eligibility and enrollment system, Illinois should apply for new federal funding to streamline and upgrade their Medicaid eligibility systems in preparation for the changes resulting from the ACA in 2014. These upgrades to Illinois' Medicaid eligibility system will potentially be eligible for an enhanced federal matching rate of 90 percent for design and development of new systems and a 75 percent federal matching rate for maintenance and operations. The 90 percent matching rate will be available for both the exchange-related Medicaid eligibility system changes as well as for those Medicaid system changes not directly related to the exchange. Furthermore, the new eligibility rules and the interactions between Medicaid and the exchange will require significant training and education of HFS agency staff as well as community based organizations that interact with low- and moderate-income individuals. Moreover, Illinois can leverage a portion of projected savings from current initiatives (e.g., from the integrated managed care pilot where HFS has indicated possible savings of over $200 million dollars in the first five years) and use it as leverage for the federal match.

Align Medicaid rules and verification with "no wrong door" enrollment system. The success of the Exchange will depend greatly on its ability to establish a streamlined enrollment and eligibility system that is seamlessly linked to Medicaid. Illinois needs to apply policies that will facilitate the development of a "no wrong door" enrollment system, including aligning, to the greatest extent possible, Medicaid rules and verification requirements. This also includes developing dynamic technology applications that will facilitate the connection between the Exchange and Medicaid programs and place less of a burden on families navigating in between.

Consider extending the use of the enrollment information for application in other programs. The Exchange presents an enormous opportunity to inform visitors of their potential eligibility for other benefits or credits, such as SNAP, WIC, TANF, childcare subsidies, or the Earned Income Tax Credit, and to simplify the process of applying and documenting eligibility for these income- and work-supports. The Exchange would be the most efficient portal for enrollment in these other programs.

Work with exchange to ensure overlapping plans and provider networks with Medicaid. Given that low-income people will likely move often between Medicaid and the Exchange, Illinois needs to build coordination between the delivery systems used by the exchange and Medicaid, including offering the same plans and creating overlapping provider networks. In this way, individuals will be able to keep their same medical home as they move between Medicaid

and private insurance. Also, we recommend creating a mechanism to identify and report when this coordination is not working in order to help prevent individuals from falling through the cracks.

Implement data-matching to the greatest extent possible in eligibility enrollment, renewal, and outreach processes. The ACA requires that the Exchange and Medicaid participate in "data matching," in which preexisting federal data is used to establish, verify and update eligibility. In light of ACA's emphasis on more cost-effective eligibility determinations that place greater reliance on electronically available data, Illinois should use a renewal process that de-emphasizes or eliminates reliance on paper-based communications with beneficiaries and unnecessary forms and paperwork**.** Many ACA provisions (other than those specific to Medicaid) also seek to move states in the direction of paperless verification and electronic enrollment.[4] And states' receipt of federal funds for health information technology investments may be made contingent on compliance with these requirements. Thus, Illinois' Medicaid program needs to ensure that it is in step with these provisions and ensure that it does not rely on paper verification for enrollment and annual renewals.

Toward this end, Illinois should institute a Medicaid internet portal now that will be later integrated into the Exchange. Illinois should allow its Medicaid enrollees to be able to verify and update their files at any time, including changing their medical home status, via an Internet online portal. If the enrollee updates their account with income information that then changes their status as to whether or how much cost-sharing they are responsible for, these changes should be immediately reflected and processed in their file. The updated income information can also serve to renew or extend the enrollees' Medicaid coverage for another full year, using pre-populated data to the extent feasible now. Oklahoma's Medicaid program provides many of these on-line services to its enrollees. Stabilizing enrollment and renewal processes will stabilize or decrease administrative costs. When eligible people fall off the program it adds to the administrative costs. Moreover, states that have instituted these changes report that they have successfully lowered administrative costs and increased client satisfaction. Finally, getting these processes in place now will provide a much easier transition for enrolling and retaining the newly eligible population.

[4] See Section 1411(c) of the Affordable Care Act.

CARE MANAGEMENT AND THE INTEGRATION OF MEDICAL SERVICES INTO THE MEDICAID PROGRAM:

Recommendations:

Illinois should ensure all Medicaid enrollees have meaningful access to care coordinators. These care coordinators would be responsible for ensuring that when an individual is referred to a specialist by their pccm/ medical home, or referred for other necessary follow-up care or treatment, that the enrollee actually receives that specialty care and/or treatment. Often, enrollees fall through the cracks due to inability to get an immediate appointment with a specialist, transportation difficulties, or other issues, which results in delaying or forgoing necessary care, increasing the likelihood of an expensive emergency room visit.

RECOMMENDATIONS OF OTHER CHANGES TO IMPROVE THE MEDICAID PROGRAM:

Recommendations:

Illinois should continue to support and enhance its patient centered medical home model. In 2006, the HFS moved to a primary care case management model to ensure that HFS clients have a medical home, creating a primary care provider (PCP) network of over 5,600 primary care physicians, clinics and other providers who have agreed to create a medical home for their clients. Approximately 1.9 million of the 2.5 million total patients enrolled in HFS Medical Programs are required to enroll in this network, which also provides services such as assisting clients with making appointments with their medical home and helping clients locate specialty providers and ancillary medical services. Numerous studies have shown that patients who have access to a medical home have better health outcomes and lower healthcare costs. Illinois' current medical home model should be expanded to ensure adequate provision of care to all new enrollees, including the newly eligible population, who most likely have never been connected to a primary care provider. Illinois should apply for all available federal funding to assist in achieving this goal.

Illinois should consider adding an academic detailing program for all Medicaid providers for pharmaceutical drugs. Currently, Medicaid excludes coverage of over-the-counter smoking cessation drugs, barbiturates, and benzodiazepines. However, the ACA eliminates these exclusions beginning January 1, 2014 and will require coverage of smoking cession drugs for all Medicaid populations. For all drugs, Illinois should consider adding an academic detailing program for all Medicaid providers for pharmaceutical drugs. Academic detailing programs provide prescribers with objective information on prescription drugs, based on the best available evidence-based science. These programs have promoted safe and appropriate drug use and improved physician practices and outcomes. They also achieved cost savings in other states,

including Pennsylvania, while positively affecting patient quality of care. Wisconsin Senator Kohl proposed a national academic detail program.

Explore the option of enrolling the children of state employees in CHIP. Section 10203 of the ACA enables states to enroll the children of state employees in the federally-matched Children's Health Insurance Program (CHIP) if certain conditions are met. While CMS has yet to issue guidance on this new option, Illinois should consider exploring this approach in light of the substantial federal matching funds that come with CHIP coverage and the potential savings given Illinois' current fiscal difficulties. This option could also benefit some state employee families, for example, those paying more than five percent of their income.

Illinois should continue to implement CHIPRA bonus performance processes. Illinois should continue to implement CHIPRA bonus performance processes, which could continue to earn Illinois a second state performance bonus from the federal government (for children enrolled through October 2013). These performance bonus activities include:
Presumptive eligibility determinations: The ACA allows Medicaid-participating hospitals to make presumptive eligibility determinations for all populations regardless of whether the State Agency chooses to expand presumptive eligibility. This provision could potentially give many more low-income individuals access to Medicaid-covered services at the point of service—their local hospitals. This option would allow Illinois to make presumptive eligibility determinations for parents and childless adults. While the ACA allows hospitals to proceed without state approval, the success of this new option would still depend to some extent on the State's involvement and cooperation in assisting hospitals with implementation. This provision provides an excellent opportunity for Illinois to improve outreach and enrollment well beyond its current presumptive eligibility program (which is available to children under 200 percent of poverty level in All Kids and for pregnant women applying for Moms and Babies (usually referred to as MPE).)
Income verification: CMS guidance states that section 1902 of the Medicaid Act requires States to use methods of determining income that are reasonable, consistent with the objectives of the Medicaid program, simple to administer, and in the best interests of the beneficiary. Illinois needs to ensure that any changes to their current process are in compliance with CMS guidance and aligns with reform efforts.

Illinois should allocate a portion of projected cost savings towards increasing provider reimbursement rates, especially for specialty and dental care. While the ACA's "maintenance of effort" provision does *not* prevent the State from decreasing services or reducing provider reimbursement rates, the State should maintain or increase provider reimbursement rates in order to keep these providers in the program, especially in light of the influx of new enrollees in 2014. In fact, Illinois can allocate a portion of projected savings from current initiatives (e.g., from the integrated managed care pilot where HFS has indicated possible savings of over $200 million dollars in the first five years) and use it to increase access to specialty care providers and dental care.

Illinois should explore adopting the Basic Health program for low-income people. Through ACA, Illinois has the option of establishing a "Basic Health Program" for low-income individuals not eligible for Medicaid as long as their household incomes are less than 200 percent of the federal poverty level. With this program, Illinois would contract directly with private plans to provide coverage and would receive 95 percent of the federal subsidies that would have been paid to individuals who receive premium credits for coverage in the new exchange. Basic Health Plans must include at least the "essential health benefits" available through the exchange. Illinois should explore this approach for low-income people under 200 percent of poverty level if it is determined to be more efficient and cost-effective than having these individuals purchase coverage through the new health insurance exchange. The Basic Health Program has the potential to provide more seamless coverage for families that experience an increase in income that makes them ineligible for Medicaid while allowing them to remain enrolled in a similar form of publicly subsidized coverage with a similar benefits package. Illinois could also design this "Basic Health program" to allow parents and children to be covered under the same health plans--use the same plans in its Medicaid program and its "Basic Health program" so that a family could potentially enroll in "family coverage," or at least have coverage that includes the same provider network and/or cost sharing system for children (who are on Medicaid) and their parents (who are ineligible for Medicaid but meet the eligibility requirements for "Basic Health"). Such plans might well be easier for families to understand and use, which would thereby improve their access to health care.

Illinois must ensure that services are provided to meet the needs of individuals with limited English proficiency (LEP). Illinois must ensure that its computer systems for Medicaid and the exchange generate notices and other vital documents to LEP individuals in their native languages. CHIPRA already increased the federal administrative matching rate for translation and interpretation services to children to the State's regular CHIP match rate plus 5 percent. Illinois should take advantage of this additional federal financial assistance to provide meaningful access to LEP individuals as part of its efforts to implement the Medicaid provisions of health care reform.

Ensure transparency and inclusiveness during reform implementation. Illinois should establish an advisory committee that includes consumer representatives and advocates for low-income persons and consult these stakeholders on the issues that affect the health of vulnerable Illinoisans. Illinois should make transparent decisions and use the public process for significant policy changes that affect large numbers of low-income Illinoisans. This would ensure an opportunity for public comment on key policy issues affecting vulnerable populations.

Consider state plan amendments to expand Medicaid covered services to include services associated with social determinants of health. Illinois should consider proposed plan amendments to expand Medicaid covered services to include services associated with social determinants of health which are not currently covered by Medicaid. These services include supportive housing, temporary transitional housing (e.g., after a hospital discharge), case management, community mental health services. While approval of this plan amendment might

cause a short term increase in the Medicaid program spending line, in only a slightly longer term that increase would be offset by a decrease in spending on unnecessary acute care episodes. Moreover, even in the short term these plan amendments would significantly decrease the overall spending of state funds by bringing in federal match dollars to fund otherwise 100 percent-state-funded services.

Re-brand the Medicaid program to reduce any stigma in order to have the best chance of success in enrolling the highest number of eligible people. The Medicaid program should be re-branded to reduce any stigma of it being a public health insurance program in order to have the best chance of success in enrolling the highest number of eligible people (and thereby yielding the highest possible federal match). Aside from employer-sponsored insurance, Medicaid is the largest source of health insurance in our state as in our country. According to HFS, approximately one out of every four Illinoisans (24 percent) will obtain their health insurance coverage from the Medicaid program after 2014. Thus, Medicaid should be promoted in outreach and other communication materials as a coverage pathway to comprehensive, free health insurance for people who happen to be low-income (in contrast to a public welfare program), in the same way that Medicare is the health insurance program for persons who happen to be aged 65 or older.

Thank you for the opportunity to make these recommendations.

Sincerely,

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